

**University College Hospital, Ibadan
50 years of Human Health Resource
Development.**

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INTRODUCTION

Fifty-two years ago, the ambition to read medicine at the University College Hospital, Ibadan made me a frequent visitor to Ibadan in preparation for the entrance examination. I was a frequent guest of a friend and classmate who lived in the unventilated garage of Dr. (later Professor) Sanya Onabamiro, the famous Nigerian Scholar and parasitologist. My friend, Festus Osiyemi, (now a retired professor of biochemistry) and Dr. Sanya Onabamiro were brothers-in-law.

The train journey from Lagos ended opposite the central post office in Dugbe, Ibadan. In the skyline, as you faced east on the way to join Oyo Road for the university campus, was a massive building under construction. It was Nigeria's premier university teaching hospital: The University College Hospital (UCH). It was magnificent as it stood propped up by an extensive network of scaffolding. It was an inspiring sight which had a multiplier effect on my ambition to be a doctor. I dreamt of the day that I would become one and work in that hospital when completed.

The dream became a reality twelve years later. The reality lasted thirty-two years and ended with my headship of the institution as the chief medical director, for eight years. Today, almost ten years after retiring, I stand before you in celebration of the Golden Jubilee Anniversary of the University College Hospital. To God be the glory. I must thank the current hospital leadership for counting me worthy on the occasion to be the 'special guest lecturer', an opportunity which, for me, in a moment of deep reflection, is not only an emotional experience but also a reason for personal thanksgiving.

This lecture is not just to serve as a selected moment to beat the chest in celebration of the achievements of the University College Hospital since its establishment fifty years ago. It is also to take stock and project a little, in the light of shared experience, what the future foreshadows in the next fifty years. In many situations, our past experiences are not always totally relevant. They could even be unpleasant, given new realities, new opportunities and new dispensations. Yet we must, following the admonitions of Maya Angelou, continue to face the wrenching pains of the past if only to avoid re-living them. The rags of today once occupied our wardrobes in pristine splendor. The need to appraise and reappraise human endeavour is unending. The responsibility to change direction, if necessary, is a bounden duty.

Given that the University College, Ibadan had a Faculty of Medicine as a foundation discipline in 1948, it was most appropriate to plan for the growth and development of clinical medicine and in the process recognize the holistic dimension of human health manpower needs. The founding fathers and the only woman, the mother among them, Professor Beatrice Joly, knew this. Adeoyo Hospital and the Jericho Nursing Home served as temporary bases for clinical practice, as well as transit camps for staff recruitment. It was patently clear that the emergence of a purpose-built teaching hospital in Ibadan was only a matter of time. When it came, it was appropriately named the University College Hospital (UCH). It was to assume a needful part, collaborating with other institutions which relate to the health sciences all over the world, in the purposeful function of human health resource development in Nigeria.

As I collate these epic events fifty years on, this lecture will, in reminiscence, invite us to judge if we have fought a good fight, finished the race and kept the faith. What we are in the position to ascertain, is whether the crown of righteousness will remain reserved for us without our continually appraising and assessing the relevance of our purpose and the quality and impact of our performance. If we adhere to St. Paul's valedictory trinity to Timothy and honestly account the available and credible evidence, we shall see that the finishing-line for us in UCH is still far off. We have not finished the race. Indeed, some will say that the race has hardly begun.

The decision to purposely build a teaching hospital had the *fundamental objective of providing Nigeria with a steady supply of highly qualified Nigerian doctors* (Philipson, 1952). This was the testimony as broadcast by Sir Sidney Philipson, chairman of the Provisional Council of the University College, Ibadan, over the radio on the 31st of July 1952 to the people of Nigeria to solicit their support for the decision. Even as a colony and protectorate in the British West Africa, it was still considered important to democratically involve the people of Nigeria in the project, that is, in a commitment that all must share.

It is reasonable to surmise that Sir Sidney used the word 'doctor' because he was addressing the Nigerian people who had been critical of the production of 'assistant medical officers' by the Yaba Medical School. In addition, nearly all hospital employees at that time were referred to by the public as 'doctors'.¹

In time, UCH was enacted by an ordinance which took effect on the 6th of October 1952 as a hospital *which shall be capable of providing such facilities as are usually provided in medical schools forming part of a University in the United Kingdom for the instruction of medical students in such subjects as are usually taught in such medical schools* (Adeloye, 1998).

The initial composition of the Board of Management had interesting features:

- a. The chairman, Sir Sidney Philipson, was also the chairman of the Provisional Council of the University College.
- b. The deputy chairman, Sir Kofo A. Abayomi, was also a member of the Provisional Council of the University College.
- c. The Academic Board of the University College was represented by the principal of the college, Dr. J. T. Saunders, Professors Alexander Brown, Beatrice Joly, Oladele Ajose and Dr. John Lawson, a senior lecturer in the Department of Obstetrics and Gynaecology.
- d. Community interest was represented by Dr. A. S. Agbaje on the nomination of the Ibadan Native Authority.
- e. The financial secretary and the inspector of medical services as ex-officio members.

The future of health manpower development and the establishment of a hospital primarily designed for training informed the decision to establish a 'school of nursing' at the old university site at Eleyele. It opened with twelve students in two batches of six on 1 July 1952. By 1954, - before the laying of the foundation stone of the hospital on 30 November by Sir John McPherson, the governor-general of the Federation of Nigeria – the number of nurses in training had risen to ninety-nine, the deliberate policy to exclude boys as prospective candidates notwithstanding.

It is important to make the point in commendation, that assembling a composite take-off 'board of management' in conjunction with establishing a school of nursing two years before laying the foundation of the hospital, is an indication of the great foresight and a demonstration of a clear focus and intent by the Nigerian House of Representatives and its leadership. The planners put a great deal of stock in carrying the people along – initially by a nation-wide radio broadcast by Sir Sidney Philipson, then by the inclusion on the board of a nominated representative of the people of Ibadan.

The hospital, close to completion, was visited by Queen Elizabeth II, and her husband, Prince Phillip, on the 14th of February, 1956. They were on a royal visit to Nigeria and specifically came to Ibadan to open the Western Region Parliament on the 15th of February.² It was in 1957 that the University College started fulfilling the reason for its creation. Medicine (1948), surgery (1948), Obstetrics and Gynaecology (1948) and Community Medicine (1948) were the foundation departments in the University College, Ibadan. Starting as 'units' and then as 'sub-departments'. Paediatrics grew out of medicine to become a full-fledge department in 1962. In the same fashion, radiology followed in 1963. Five autonomous departments grew out if the Department of Surgery, namely Ophthalmology (1962), Anaesthesia (1966), Otorhinolaryngology (1969), Dentistry (1981), and Physiotherapy (1982).

It is of historical interest to note that the first outpatient consultative clinic in UCH was run by Dr. (later Professor) Frank D. Martinson in ear, nose and throat surgery (Adeloye, 1998). Psychiatry, neurology and neurosurgery functioned as a neurosciences group in 1963, until neurology and neurosurgery found their natural habitats in medicine and surgery, leaving psychiatry to further expand its frontage into the behavioral sciences.

The Department of Pathology commenced in UCH in 1961, with Dr. B.G.T. Elmes as its foundation head, assisted by Dr. G.M. Edington and Dr. A. Olufemi Williams.

Although clinical laboratory services had been available at Adeoyo Hospital since 1956, the Department of Chemical Pathology did not assume an identity until 1961, when Dr. J. Edozien (now his Royal Highness, the Asagba of Asaba) was appointed professor and head of the new department. Like the clinical departments of medicine, surgery and obstetrics and gynaecology, the Department of Pharmacy had its beginnings in 1953, in the 'transit camp' of Adeoyo Hospital.

With effect from 1957, clinical students no longer had to go to teaching hospitals in the United Kingdom to complete the curriculum for a London University degree.

Staff recruitment from overseas institutions became easier. International organizations scrambled over one another to fund research, establish research foundations and sponsor exchange programmes. The University College Hospital functioned as a true centre of excellence. It was rated in the unit position among the best teaching hospitals in the British Commonwealth in the early 1960s, even above some older teaching hospitals in London that had given it breath and life.

Initial demonstrations of community concerns were taken care of, and the University College Hospital functioned firmly, secured behind a chain-link fence as a well-illuminated set-up with its own uniformed guards. There were social and recreational facilities for the exclusive use of its senior staff and invited guests. Patients attending the hospital were either referred from other hospitals, nursing homes or private clinics or through its 'outpatient clinic' where patients are 'sorted out' according to the needs of the various clinics for teaching purposes.

¹ Fifty years on, believe it or not, in embarrassing continuity, a theatre orderly or a security man working in UCH can still do brisk business as a 'doctor' away from the work place in their home or rural environment.

² The hospital was officially commissioned on the 20 November 1957, by Mary, the Princess Royal (see frontispiece, page ii).

The journey so far constituted a take-off platform for human resource development in health. The ingredients of a solid beginning for such development ordinarily consist of facilities to provide excellent clinical services, in total creating the enabling environment for academic activity and research. The University College Hospital was appropriately built and equipped for this purpose. A well-motivated work-force capable of giving leadership in the various units and departments and willing to work in concert for effective outcome was in place. There was adequate inducement for competent trainers attracted not necessarily by the size of pay, but by the excellent up-to-date facilities which uplifted morale and promoted intellectual growth. Opportunities for professional recognition abounded locally and internationally. Research outputs flourished and scientific publications, by the measure of their quality, appeared in international scholarly journals with comparative ease and frequency.

The first products of UCH as a human health resource development centre were nurses. Miss L.M. Bell was the first principal of the School of Nursing. She had four other expatriate tutors as assistants. The first senior indigenous member of staff of the school was Mrs. Florence Ogunbiyi who joined in April 1952 as 'home sister'. She was followed by Mrs. R.O. Solanke, in an equivalent capacity.

When the day of reckoning came, Miss Bell was so confident of the standard of nursing education in UCH that, by-passing the all powerful regional matron at the Health Department in Lagos and the registrar of the Nursing Council and secretary to the Midwives Board of Nigeria, she invited the General Secretary Council of England and Wales to examine her students. Miss Bell, former principal senior tutor at St. Thomas Hospital, London knew the nursing requirements of a teaching hospital and had three strategic objectives *ab initio*:

1. Although informal male-dominated nursing education commenced as apprenticeships in mission and some government hospitals in Nigeria following the enactment of the Midwives' Ordinance in 1930 (Adelowo, 1989), Miss Bell recognized that the level of basic education needed upliftment for teaching hospital purposes. Like Florence Nightingale, she believed that the intellectual component of nursing was the essence of intelligent care that could contribute to the quality of health manpower development through clinical services, research and training. Hence, only girls with form VI school leaving certificate were admitted for nursing education in the UCH.
2. She wanted an accreditation of the UCH School of Nursing by the General Nursing Council of England and Wales in order to secure reciprocal recognition of the certificates issued. By so doing she would also ensure parity in the remuneration of UCH-trained and overseas-trained nurses. Hitherto, like Yaba-trained assistant doctors, Nigerian nurses could never rise higher than being assistant nursing officers.
3. The pioneer students could go to train as midwives in the United Kingdom without taking a qualifying

examination. In addition, the reciprocity allowed Nigerian nurses trained in the United Kingdom to be employable in their country without having to take the qualifying examination of the Nursing Council of Nigeria.

Through UCH, a revolution in nursing manpower development in Nigeria commenced. Among the foundation students was Miss Stella Teteku (later Mrs. Bankole) who retired here as assistant matron. Matron was the highest post in the nursing services at that time. I remember Miss Theresa Thresize, because she was my late wife's schoolmate at the Holy Child College, Lagos and married my teacher (*alias Ki Lo Gba*) at the CMS Grammar School Lagos to become Mrs. Phillips. The standard of UCH nursing was replicated in various parts of Nigeria, across West Africa and beyond. Subsequent sets included many nursing icons, the details of which cannot be given within the time at our disposal. But we must mention that bubbling bundle of agility with a ready smile and disarming intelligence, Mrs. Remi Ogunlana (nee Johnson) who, to the best of my knowledge, was the first nurse to head the nursing services in two teaching hospitals in Nigeria. Or shall we forget that nurse-educator, Mrs. Omobola Alada (nee Thomas) who touched the lives of many through love, devotion to duty, and the keeping of family values to the envy of many. Miss Bisi Soretire (later Mrs. Chinda) became a theatre superintendent in LUTH. Miss Ogbitse Sagay (later Mrs. Ossai) was last traced to the Department of Public Health in the Faculty of Social Sciences in the University of Benin. Pretty Miss Sophia Mohammed (later to become Mrs. Usman) was principal, School of Nursing, Zaria. Miss Beatrice Alonge (later Mrs. Egbon) moved to the School of Nursing, Benin. Miss Rose Fawep (later Mrs. Adamu) was in public health and now runs a primary/secondary school in Jos.

This list is nowhere near exhaustive. The intention is to show how UCH positively influenced health manpower development in Nigeria, so much so that, today, nursing is an academic programme in the associate University of Ibadan as in universities elsewhere.

In addition, there has since been established a School of Midwifery (1952), a School of Medical Laboratory Technology (1973), a School of Medical Records and Biostatistics (1976), A School of Health Teachers, offering courses and/or programmes for environmental health officers (1976), nurse/midwife/public health nurses (1978), community health officers (1979) and primary health care tutors (1984).

Fourteen medical students commenced their clinical postings in UCH in 1957 and successfully completed their training programmes to graduate as doctors with University of London degrees in 1960. They were the first set of medical students who started their training in Ibadan and finished it there. They not only had the good fortune to make history, but they also proved to be worthy of the honour by the brilliance of their

performance then and thereafter. Thirteen of them became recipients of postgraduate diplomas in surgery, medicine, paediatrics, otorhinolaryngology, obstetrics and gynaecology and pathology. The fourteenth died before he was able to sit for the final part of the examination for the fellowship of one of the royal colleges of surgeons in the United Kingdom. Five became heads and/or deans in faculties of medicine outside UCH. Six rose to the rank of professor in the Nigerian university system. Two held high positions in the civil service that gave them the direct opportunities to influence the health policies of government. One served as a state commissioner of health, another as a state governor and yet another as consultant physician to three Nigerian heads of state (Adeloye, 1998). This lecture will be tediously long if I continue to catalogue the achievements and the contributions of individuals who benefited from or owe their careers to the establishment of the University College Hospital, as about one hundred sets of students have graduated as doctors. It would take some years to collate and organize the kind of information provided by Adelola Adeloye about his thirteen classmates who passed out in 1960. Even the alumni associations are yet to tune into the need to create information reservoirs on their members.

We must not forget that University College Hospital, Ibadan was the first of the few purpose-built teaching hospitals in Nigeria. The University of Maiduguri and Aminu Kano University Teaching Hospital later qualified to be so classified. Institutions like the Lagos University Teaching Hospital were after thoughts. LUTH arose from the desire to build another hospital on the Lagos Mainland. The same could be said of the University of Benin Teaching Hospital (UBTH) under the dynamic leadership of the then military governor of Bendel State, Brigadier Samuel Ogbemudia, at the end of the Nigeria Civil War. Even then, it was the establishments and training officer of UCH who was deployed to UBTH from 1972-1975 to be the foundation house governor.

It is gratifying to note that some of the older teaching hospital, such as Zaria, Enugu, Jos, Port Harcourt and Calabar are in various states of completing their 'purpose-built' teaching hospitals on new sites. It is worthwhile to recount some of these developments in order to properly appreciate some of the contributions of UCH to the genesis and survival of these institutions.

Akinkugbe (1997), in his 40th UCH Anniversary Lecture, estimated that one in four doctors in Nigeria was trained at the University College Hospital, Ibadan. This proportion would have been higher, if he had extended it to include those who worked and taught initially in UCH before undertaking pioneering responsibilities elsewhere. They too, should be considered as part of the contribution of UCH to human health manpower resource development nationwide. Examples are Ishaya Audu (professor of paediatrics and vice chancellor of Ahmadu Bello

University, Zaria), Oladele Ajose (professor of community medicine and later vice chancellor of University of Ife), Kesley Harrison (professor of obstetrics and gynaecology, later vice chancellor, University of Port Harcourt), Festus Nwako (later professor of paediatric surgery, chief medical director of University of Nigeria Teaching Hospital, Enugu and vice chancellor of Nnamdi Azikiwe, Awka).

When LUTH took off in 1962, an impressive number of the initial staff came from UCH. A few examples which come to mind are Horatio Oritsejomi-Thomas (who later returned to Ibadan as vice chancellor of the university); Akin Adesola (who was vice chancellor of the University of Ilorin and vice chancellor of the University of Lagos); Ade Elebute (former President of the National Postgraduate Medical College of Nigeria, Provost of the College of Medicine of the University of Lagos, and most recently the chairman of the UCH Board of Management); and the late Paul Omo-Dare (the first professor of paediatric surgery in the University of Lagos and in Nigeria). I have mentioned just a few.

It is worth noting that all those named constituted the exodus from the UCH Department of Surgery alone. Notable among the others was the late Professor Olikoye Ransome-Kuti from the Department of Paediatrics who, as the Federal Minister of Health for eight years, gave Nigeria its first national policy on health with primary health care as its epicenter.

Many may not be aware that the earliest formal training of health professionals in Nigeria commenced with chemists and druggists following the Pharmacy Ordinance of 1928. The training of assistant medical officers at Yaba commenced in 1932. The contributions of UCH to national manpower development in pharmacy are significant. The Pharmacy Department commenced in Adeoyo Hospital in 1953. By 1956, Mr. F. A. Callisto had become 'senior pharmacist' and, as expected, was the first chief pharmacist of UCH. In 1962, he was seconded to LUTH for a period of six months to set up the Department of Pharmacy there. His pioneering work in Lagos was continued by Mr. J. C. Molokwu, his deputy here in UCH. Mr. Molokwu later became the substantive head of pharmacy at LUTH. Mr. Gabriel Osuide, an employee of UCH, similarly went to Ahmadu Bello University Teaching Hospital and later to Benin to establish the pharmacy wing of the University of Benin Teaching Hospital. Osuide, in addition, later climbed the academic ladder to professorship in pharmacy at Ahmadu Bello University, Zaria to become the first director of the National Agency for Food and Drug Administration and Control (NAFDAC).

I remember Mr. N.C. Ifedirah, Dr. Phillip Emafo, and Mr. E.K. Osuzoka (father of a former principal of the School of Nursing, Mrs. S.O. Ekpendu) who were not only outstanding professionals, but also great guides and counselors to young specialists like me. Mrs. Okusanya became head of the Federal Government

Manufacturing Laboratory at Yaba and was, the registrar of the Pharmacy Council of Nigeria in 1998. If I am indicted for undue affinity for the Pharmacy Department, I plead for your understanding and forgiveness. This anniversary lecturer is the eldest child of one of the pioneer students of the School of Pharmacy, Yaba in 1926. The father who begat him topped the list of passes in the Chemist and Druggist Diploma in 1932 and taught pharmacy and its allied subjects – chemistry, physics and botany – until 1936. We should not forget the role of UCH in the development of human resources in other health-related disciplines, such as physiotherapy. Although manpower development in physiotherapy had its genesis at the Army Base Hospital, in Igbobi in 1943, the Department of Physiotherapy in UCH did not start until 1952. It was based in Adeoyo Hospital with the first generation of fully professionally trained Nigerian physiotherapists such as Mr. (now Dr.) T.A. Oshin (1954), Dr. I.O. Ayodeji, Dr. J.W. Cookey-Gam (a Yaba-trained doctor who, as his sight faded, chose physiotherapy as a career), Mr. Chris A. Ajao (1957) and the first female Nigerian physiotherapist, Mrs. S.A. Ajao (nee Ajala) in 1958. I might add that handsome Dr. T.A. Oshin had an early privilege, if not the good fortune – in all its connotations – of being the single male in the group of four physiotherapists who started the department in UCH.

True to its vision in health manpower development, the UCH Board of Management awarded scholarships to three students to train as physiotherapists. One of them was Mr. J.O. Obiri, whose physical stature belied his strength. His powerful hands were matched by the precision of his palpating fingers. In many cases, he made the prolonged wearing of the cervical collar unnecessary, after a not to be forgotten neck manipulation. Beneficiaries like me remember him with great affection not only as an excellent professional, but also as a wise counselor and comforter in many personal matters.

Dr. Gabriel I. Ordia was another board of management-sponsored student who played his part in fulfilling the mission and vision of UCH by going to LUTH to start a department there. The physiotherapists were a very formidable collection of proactive professionals.

By 1959, they had formed a Nigerian Society of Physiotherapy, with the likes of the late Dr. (Chief) S.O. Awoliyi and the late Sir Mobolaji Bank-Anthony as honorary presidents from 1959-1969. They had strict rules for membership. Qualification for membership of the association was based on accredited professional standards. They developed a recognized training programme and persuaded the federal government to commence a School of Physiotherapy at UCH in 1962. However, the training programme was not to get the accreditation of the associate university for a Bachelor's Degree until 1966. The first physiotherapy students emerged three years later. The production of the *Journal of the Nigerian Society*

of Physiotherapy in 1969 added flavor to their professionalism and the stimulus to continuing physiotherapy education through the disclosure and sharing of experiences, practical and other.

There are two human dimensions to health care, the providers and the recipients. Our immediate concern relates to the amorphous group of professionals, semi-professionals and other members of the workforce with the appropriate skills and the will to work within unified system for the provision of health care. It is fashionable to refer to the amorphous group of providers as the 'health team' – a team that exists only in our dreams and perhaps finds an occasional expression in our supplications. In reality, it is nightmare of fragmented and divided professionals in search of a leader, deputy assistant leader, assistant leader, special assistants, principal assistants, special deputy principal assistant – in the fashion of Nigerian political office creation where 'leaders' may occasionally outnumber the fellowship. The juggle for who leads the team has become as laughable as the election of a 'minority leader' in one of Nigeria's legislative chamber. There, the elected members in the opposition party totalled one.

No matter how well designed and well endowed a health system is, or how sophisticated the buildings and tools for performance are, the effective benefits depend absolutely on the quality of the human resources. That quality is the sum total of knowledge, skills, motivation, devotion, commitment, empathy and compassion that puts corporate interests above self. These are the essential elements in human health resource policy formulation and the guiding principles in their implementation.

In the past few years, we have thought of, dreamt of, and spoken of health system reforms. It is not easy for a 'reformer' to know where to start. An existing system, which grew out of chaos, cannot be reformed without going back to basics of personal human values and the fundamentals of social change and sustainable development as espoused by Kwapong (1990) and Mabogunje (2006).

I need not remind you that a population census goes far beyond the counting or the guessing of the number of heads in a state. Who they are, where they are, when they were born and when they die, how they live, and how they survive are the core ingredients of meaningful planning? How do we know that the reform we envisage will not further compound our problems? I was at the forefront of the executive heads of health institution that had the duty and the responsibility to implement enhanced user-fee charges in teaching hospitals. It worked only to the extent that some services were restored by a Bamako Initiative-type of revolving fund system. In the process, we almost forgot – if we have not now totally forgotten – the primary responsibility of human resource development. The admission policy, the scope and place of investigation and the dimension of treatment became factors in what

patients could afford to pay. It was the period in which we all celebrated the advent of a National Health Policy with PHC as its core.

In a study on the effect of user-fee charges on the nursing ethos and practice at the Aminu Kano Teaching Hospital, Kano, Marama (2002) found that 52% of patients had to dispose of family heirlooms and personal assets such as rings, bangles, necklaces, clothes, and shoes among other things, to make initial monetary deposits before hospital admission was possible. Over 20% had to wait for more than a month to raise the funds and another 10% had to wait for over one year for the same reason. To make matters worse, about 16% had to abandon treatment because of their inability to meet additional costs outside the original estimate. I had this to say about primary health care in another anniversary lecture a few weeks ago. I quote verbatim:

The expectations of the policy two decades later cannot now be described as successfully achieved. We hold that some fundamentals of the programme were not in place at the various levels of implementation. Primary Health Care was supposed to be inexpensive, affordable by the state and client, accessible to the rich and poor as an efficacious health system. Central to its organization was a referral system which was to guarantee care at higher levels depending on the complexity of the cause of ill-health. The common causes of ill-health within the capacity of the village or community health attendants formed the broad base of the pyramid while the apex was the University College Hospitals, euphemistically referred to as 'centres of excellence'.

It did not take long to come to know that the system was not cheap. The referral centers had little more quality service to offer than those in the village health centres from which patients had been referred. The cost of health care had become less affordable due to the application of more sophisticated technologies for which running costs had to be recovered. The apical referral centres in time grew outside reach and became illusory tips of the pyramidal health structure. The most damaging result was the people's partial loss of confidence in modern scientific medicine, which provoked a mass exodus to syncretism, suspect religious organizations, a return to divination, spiritualism, exorcism, and the bizarre health practices of the distant past. Failure to quickly respond to all kinds of emergency situations, such as domestic trauma and road-traffic and workplace accidents (especially when there have been mortalities) completed the erosion of confidence. The tertiary hospitals lost the service components of the creation and accepted all types of clinical problems provided the patients could pay the user-fee charges. The system failed because the cost implication was unknown. Osuntokun unrelentingly warned that the isolated costing of primary health care was unrealistic unless it took into consideration the financial implications of the entire pyramidal system of health care which included increased funding for secondary and tertiary health care centres. The manpower requirements had been underestimated. The managerial skills required were not even addressed. Much more significant, was the conceptual failure that marketed a national development programme, where health is constitutionally and rightly on the concurrent legislative list, as a federal ministry of health affair. (Ajayi, 2007)

Well-meaning critics would be expected to ask: 'Faced with the enormity of the problems of reform, faced with a census that usually does not satisfactorily answer these essential questions, faced with a limited moral capacity to transparently account for services the nation renders to its peoples, should we then in frustration fold our hands and do nothing? Our inability to answer these persistent questions is probably the product of our many frustrations. We, therefore, resort to sermons at every conceivable opportunity and dodge the real but tough option.

Umaru Shehu (1996) after an agonizing but comprehensive analysis of the requirements of a credible health system reform, examined manpower resources from the standpoint of curriculum adjustment, team training and re-orientation of extant staff. Surveying the need for a prior reform of the managerial system, promotion of community involvement and participation, greater inter-sectorial collaboration and the review of financial allocations, he came down heavily in favour of *a health information system, backed by a political will, as fundamental to the organization of a rational, responsive and result-oriented health system.*

Must we continue to pretend that a health system is being reformed even when the essential ingredients of policy formulation are unknown? Can one answer questions which are not raised? Is it possible to find solutions to problems unknown?

The human capacity required for the establishment of a health information system is itself an issue germane to the topic of this lecture. Data collation is not a health science neither does it require a decade to be able to train anybody in demography and social statistics. For the formulation of successful strategies for human health resource development, we must have clear objectives with regards to coverage, quality of care envisaged, and the fixed minimal cost for a relative degree of effectiveness.

Coverage based on doctor or nurse-patient ratios has fallen into disrepute because we have no reliable information on the number of practicing doctors or registered nurses in the country. The number of beds in the private and public health sectors is unknown, thus making doctor-bed, nurse-bed ratios meaningless parameters of adequate health coverage. Untutored citizens practice medicine, nursing and pharmacy and brazenly dominate television screens under the umbrella of 'traditional medicine' or 'alternate medicine'. The titles 'Dr', 'Nurse', 'Pharmacist' have been appropriated by quacks, impostors and peddlers of fake or substandard drugs.

Official government apologists soon switched gear to declare that the problem was neither in the number of health personnel nor in the number of beds but in the inequitable distribution of health care providers and facilities in favour of the urban setting over the rural. The result was that the majority of Nigerians

who needed health care the most were not getting it. Simultaneously, Nigeria was losing its health personnel to temporary or permanent external migration. Many doctors who remained in the country opted for more rewarding non-medical occupations or a more rewarding private sector medical practice.

A disputable fact was that developed countries overseas became the beneficiaries of our investments in human resource development. The 'pittance' which they threw at our highly trained and skilled indigenes was sufficient inducement, given the state of the Nigerian economy. On the other hand, we must admit that the consequential exodus of our health professionals overseas for comparatively higher wages enabled them to meet nuclear and extended family responsibilities, as well as provide some security for the future.

The quality of our services and training plummeted. Our standard of life fell in company. Some of our thinning personnel continued to accept to serve abroad even when the rewards offered no longer matched those of the pioneer migrants.

In 2003, I was the chairman of a Special Technical Committee on the Development of Health Human Resource Policy for Nigeria, jointly sponsored supposedly by the Federal Ministry of Health and WHO. I am not surprised that the recommendations of that committee are yet to see the light of day, neither do I expect they ever will. In our many deliberations, I was chocked by a proposal by some members to push for a legislative enactment that would restrict all specialized health workers intending to travel outside Nigeria for whatever reason, which was a panic reaction to mourning threats of international predators.

Let us consider the example of a legally non-binding agreement between Commonwealth Ministers of Health, titled *Commonwealth Code of Practice for International Recruitment of Health Workers* (2002). The agreement was intended to discourage the targeted recruitment of health workers from countries which are themselves experiencing shortages, but we were quickly reminded in the same document that *this type of international recruitment provides many health workers with the opportunities to develop their careers, gain valuable experience and improve living conditions for themselves and their families.*

While it pretended to be sympathetic to the plight of loser countries, the document, in a subtle manner, pleads that the Code should be *sensitive to the needs of the recipient countries and the migratory rights of individual health professionals.*

The insult to our intelligence was not done yet. This document concluded:

The Code does not propose that governments should limit or hinder the freedom of individuals to choose where they wish to live and work.

Who says that the slave trade is over or its camouflage has been discarded?

Guiffrida and Bourassa-Forcier (2002) estimated that foreign-trained health professionals constitute more than 25% of the medical and nursing workforces in Australia, Canada, the UK, and the USA. Schubert (2002) estimated that there would be 31,000 nursing vacancies in Australia by 2006. In 2001, it was estimated that 15,000 nurses were recruited to the UK and that 35,000 nurses will be required by 2008. In 2002, the US Department of Health and Human Services estimated that the shortage of human resources for health will hit 50,000 by 2015. Yet the pattern of disease continues to change all over the world, and more so in our part of it.

Akinkugbe's team, the National Expert Committee on Non-Communicable Diseases in Nigeria (NCD), forthrightly warned us as far back as 1992 of a new Third World pandemic of hypertension, coronary heart disease, diabetes mellitus, sickle cell disorder and G6PD deficiency. To these we may safely add stroke and cancer, because the World Cancer Report of 2003 predicted a 50% increase in the incidence of new cancer cases worldwide by the year 2020. Infection and infestations would account for 23% of these cases in developing countries against 9% in the developed world.

Did we know that in the year 2000, cancer emerged as major public health problem in developing countries, matching the statistics in the industrialized countries? All these will change or substantially add to the burden of health care and disease prevention for which human health resources must be provided for effective action. I have not forgotten HIV/AIDS in its acute form and the cancer risks in long-term survivors. I have not gone this far to create fear or despondency, but to seriously invite all (UCH and all other institutions and bodies it has helped to foster over these past five decades) to appreciate the new challenge that will confront our country full face in the next 50 years.

In this exercise, we will have to work out the strategies necessary to combat the threats, develop and protect our human health manpower and defend our interests in a predatory world. To do that, we ourselves must sharpen our focus on the problems of manpower development, utilization and retention. We must tap on the experience and the competence of our citizens and seriously listen to their advice regarding the possible options for the solution of our problems. It is self-evident that the best custodian of our national interest must be ourselves. *Our* lives cannot be in *their* hands, that is, it must not be in hands other than our own.

I shall never tire of reminding anybody close enough to hear that the World Health Organization is not more than a World *Help* Organization. Let us examine how countries in similar circumstances have fared. Together, let us look at experiences and proffered remedies elsewhere, mostly in Asian countries. Indeed, some of them are not entirely new to Nigeria. We must repeatedly caution ourselves not to forget our

past since otherwise, as the saying goes, we might be condemned to relive it.

Some suggestions have included an increase in the output of 'medical, nursing and other professional health workers quickly, cheaply and superficially to handle life-saving expediency in the face of exploding populations and declining economic fortunes;' that to do so, would be a much more appropriate ethical response to an increasing population of the sick than professional Puritanism (Garrido, 1997). It has also been suggested that the number of specialists should be increased by lowering the end-point of training (Ikeme, 1996). The World Bank (1993) was most brazen in calling for...

...a reduction of government expenditure in tertiary facilities, specialist training and interventions that provide little gain for the money spent.

These are samples of the views with which developing countries have been inundated for many years. Is there much evidence that our government have in no uncertain terms rejected many of these suggestions? The usual channel of enforcing these insensitive foreign 'solutions' to our problem was the infamous so-called 'conditionality' of the International Monetary Fund, when nations begged for a rescheduling of their national debt. Though personally disinterested in partisan politics, I think one ought to commend the last government of Nigeria for paying off some of our dubious foreign debts. These debts, conflatting with other corrupt inducements, make us susceptible to bad advice and render us vulnerable to international conspiracies and blackmail.

We have, at different times, proposed remedies which can only be given full expression when we accept the supreme importance of a health information system reform. Health informatics is so fundamental that by ignoring it, no meaningful solutions can be seriously tabled for consideration. Meantime, we must renew our resolve to give the same attention as we give to doctors to the education of nurses, pharmacists, laboratory scientists, physiotherapists, occupational **the development of manpower in health informatics.** We must look again at who does what or can be equipped to do what in our health manpower development.

In the Republic of The Gambia, as far back as 1998, a Nigerian doctor with her team trained nurses to perform eye cataract extraction. In time she went on to enhance the skills of particularly talented ones among them, in the many steps up, by including lens implantation. The doctor was Hannah Faal, one of the several generations of ophthalmologists inspired, tutored and trained in UCH under Professor (Mrs.) Oyinade Olurin, the Head of the Department of Ophthalmology from 1976 to 1982. Professor Olurin stands tall in our admiration and appreciation for her contribution to health manpower development in ophthalmology. She is generally regarded as the 'Grandmother of Nigerian Ophthalmology', an

adornment she wears shyly, and an affectionate accolade she carries most reluctantly. Why then can we not consider single-skill capabilities to deal with pressing health problems such as preventable blindness in some parts of this country, while concurrent preventive measures are given a chance and time to become effective? Why can we not train nurses in emergency life-support programmes to include such interventions as venous cut-down, endo-tracheal intubation, and cardiac resuscitation, as has proved to be effective elsewhere?

The several professional health boards or councils that have been created to regulate the practices and other activities of the various professional groups are yet to effectively sustain standards and promote growth in the number of professionals, neither have these bodies come forward with innovations to meet the challenges to services in our many communities. The unending juggle for administrative power, professional superiority and exaggerated worth hug the newspaper headlines to the derision of persons of discernment. Titles and positions take precedence over the assessment of relevant skills and cognitive ability, while the quality and the length of training are subsumed in the crafting of a schedule of duty that seems to suggest that a good omelette is only produced if the cook is also the poultry farmer.

At our anniversary celebration ten years ago, the very distinguished guest lecturer admonished that it was time for UCH to commence an amendment of life. He knew from his vast experience and feared that *negative forces will surely work hardship on a quick turnaround of the fortunes of the UCH, for the last to change is the human factor...* The decision to focus this anniversary's lecture on human resource issues in the past and the present underlines what Akinkugbe identified as the *weakest link in the chain*. While we must seize this opportunity to commend the attempt of the federal government in the last ten years to refurbish, renovate or upgrade teaching hospitals and the federal medical centres, we all must also know that our ultimate success will hinge on human resource capabilities, commitment and grit. We must admit that there is a cost to training. In 1992, the hospital administration created a *Residency Training Fund*. I cannot tell you if it is still in place. We insisted that fees accruing from respective hospital training programmes shall be devoted solely to the prosecution of the respective training programmes. We must not continue to have a Directorate for Clinical Services, Research and Training without an operational budget. We must give sincere and equal attention to the education of the health team in medicine, nursing, pharmacy, laboratory science and physiotherapy. We must fully resuscitate occupational therapy, restore the dignity of dietetics in health care and create departments of health information at local, state and national levels. There is no way we can solve our problems without an accurate determination of the nature and size of the problems. We must look again at who does what and who, really, should do what. We must maximize the potential of every health worker

to function effectively. We must upgrade skills as has been done elsewhere. We must make the acquisition of management skills a mandatory requirement of health care training. In my address to the Chairmen and Chief Executives of Teaching Hospitals in November 2001, I had this to say then and I repeat it now to end this lecture:

It is my firm belief that effective health care delivery, even within the existing limitations, can be transformed if health care providers at all level recognize the importance of placing organizational needs above personal considerations, recognize the essence of contrasting points of view and recognize personal strengths and limitations. They must have the penchant for giving a helping hand, have skills in effective communication, have skills in counseling others, have skills in promoting and sustaining loyalty, skills in building trusts, confidence and teamwork; and have the ability to make others feel as important in a management structure as themselves. Health care providers must be more than just nice people. The principles of personnel management, the management of information, strategic planning, implementation and evaluation, organizational development, cost-effective concepts and analysis, drug management, the social marketing of health plans, programmes and products are crucial to the emergence of a good health manager and the effectiveness of any healthcare delivery, more so when resources are limited....

May God continue to keep and bless UCH.
Happy Anniversary!

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